Mental Health Care Use in Later Life: Results From a National Survey of Canadians

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Objective: To estimate the proportion of older adults who have used mental health services in the past 12 months among those who meet the criteria for one or more Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, 12-month psychiatric disorders. We also examine the factors associated with mental health care use in this population.

Method: We used secondary data from the Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2). We first estimated the proportion of adults aged 55 years and older who used a range of mental health services. Next, using logistic regression, we examined the relative contribution of predisposing, enabling, and need characteristics in predicting any service use in this population.

Results: Among the 12 792 adults aged 55 years and older in the CCHS 1.2, 513 (4.23%, 95% CI 3.89% to 4.95%) met the criteria for at least one 12-month DSM-IV disorder. Among these respondents, 37% (95% CI 31% to 43%) saw at least one type of mental health care provider in the past 12 months. Visits to a general health care provider for mental health reasons were most common, followed by specialist care. Only psychological distress was significantly and positively associated with using mental health care services.

Conclusions: Over 60% of the older adults who met the criteria for a DSM-IV disorder were not using mental health care services. Social and demographic factors did not predict service use in this population.

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Clinical Implications

- Close to two-thirds of community-dwelling older adults who met criteria for major mental disorders in the past 12 months did not seek services in either the speciality mental health care sector or general medical care setting. While not all would necessarily require services, the numbers raise concern about undertreatment in this population.
- Among the older adults who did use mental health services, most sought help in a general health care setting. Clinicians working in these settings should be aware that older adults may bring mental health concerns, as well as physical health problems, to their medical encounters.
- Among those who did seek care, distress was the only significant factor associated with use. Access to care does not appear to be influenced by non-need (predisposing and enabling) factors in this population.

Limitations

- The relatively low prevalence of disorder among older adults, the low numbers of older adults with disorder, and the low number who sought out mental health services limited the complexity of the analysis and our ability to look at predictors of individual care providers.
- The measures of disorder and service use rely on self-report, and are thus subject to recall bias.
- These data did not include measures about other factors influencing service use, such as attitudes toward mental health care or knowledge of available services.

Key Words: *mental health service use, Andersen model, older adults, World Mental Health–Composite International Diagnostic Interview, population health*

In recent decades, investigations into the rates and predictors of mental health service use in large, population-based studies have demonstrated the extent of unmet need, as well as the degree to which service use is influenced by social and demographic factors.[1–4] Unmet need refers to the discrepancy between the number of people who meet diagnostic criteria for any disorder, and the number of people who report having sought care for their mental health or addiction problems.[5] The social and demographic correlates of mental health care use in early and middle adulthood are well known. In addition to both objective and perceived need,[6–8] being female[2–4,9]; previously married[6,8,9]; of higher socioeconomic position[4]; and non-black, non-Hispanic ethnicity[6] are all associated with greater use of mental health care. In the United States, third party insurance coverage is also a significant predictor of help seeking for mental health.[10] Previous research suggests that among people with disorder, older adults are less likely to use services than their younger counterparts.[8,11] As such, a better understanding of the predictors associated with help seeking in this population is necessary. Our limited understanding of the factors associated with mental health care use among older, compared with younger, adults is partly related to the paucity of contemporary population-based data assessing mental health and service use in adults aged 55 years and older. Prior to the release of surveys such as the NCS-R in the United States,[3] most of the major epidemiologic studies of the past 10 or more years have excluded adults aged 55 years and older altogether,[2] rendering an examination of predictors of use in old age impossible.

While Canadian data have been previously used to estimate mental health service use in the population, the regional nature of the data, the exclusion of older adults, or the failure to look at rates of service use by age group, limit our ability to generalize the findings more broadly to older adults in Canada. For example, using data from the Ontario Mental Health Supplement, Offord et al[12] reported that, in the general population, 7.8% of respondents reported some contact with either formal or informal health care providers for mental health reasons in the recent 12 months. Among respondents who met the criteria for a DSM-III-R disorder, only 20.8% reported the use of mental health services.[13] However, their study excluded adults aged 65 years and older. In the Edmonton study,[14] although adults aged 65 years and older were included, estimates of service use by age group were not provided. Finally, Lefebvre et al[7] estimated mental health service use in a French-Canadian population in Montreal, but did not provide estimates by age group.

Only 2 regional studies in Canada provided estimates of service use for older adults. In a subsequent survey[8] conducted in Edmonton, 16% of adults aged 65 years and older who met the criteria for a 12-month disorder (including GAD and PTSD) sought help for mental or emotional problems. More recently, Préville et al,[15] using data from a sample of adults aged 55 years and older in Quebec, found that 39% of adults who met the criteria for 1 or more of 7 major psychiatric disorders had sought care in the previous 12 months. Prevalence of service use for specific disorders varied from 8% among those with specific phobias to 50% for major depression. The vast majority of older adults in this survey (80%) sought care from a family physician.

In our review of the international literature, we found only 2 studies that specifically examined rates and correlates of mental health service use, both of which used nationally representative samples of older adults from the United States. Klap et al[11] found that of the 8% of adults aged 64 years or older who met diagnostic criteria for at least one of the common disorders measured in the survey, 53% had sought care for mental health reasons in the previous 12 months. Presence of mental disorder, perceived need for care, chronic physical health problems, and perceived physical health status were all correlated with service use. The only non-need factor associated with seeking care was health insurance coverage. More recently, using data from the National Survey on Drug Use and Health, Karlin et al[16] found that of the 3.4% of adults aged 65 years and older who met the criteria for serious mental illness (defined as a score of 13 or more on the K6), only 9% reported receiving outpatient mental health care in the recent 12 months. This study also examined service use rates among respondents meeting the criteria for specific 12-month syndromes approximating DSM-IV diagnoses of 12-month major depression, panic attack, social phobia, GAD, agoraphobia, PTSD, and mania. Among the 8.9% of older adults who met the criteria for at least one syndrome, only 10% reported service use.[16] Poor self-rated health and the presence of one or more syndromes were the only significant predictors of service use. In other work where national data have been used to examine service use among older adults, the focus has been on mental health service use for depression only,[17] or on provider-specific estimates of service use (psychologists).[18]

Abbreviations used in this article

ADL	activities of daily living
CCHS 1.2	Canadian Community Health Survey: Mental Health and Well-Being
DSM	Diagnostic and Statistical Manual of Mental Disorders
GAD	generalized anxiety disorder
MOS	Medical Outcomes Study
NCS-R	National Comorbidity Study—Replication
PTSD	posttraumatic stress disorder
WMH-CIDI	World Mental Health–Composite International Diagnostic Interview

In addition to estimating the prevalence of service use, understanding the clinical and nonclinical correlates of use is important. Canada's population, like many industrialized nations, is aging,[19] and understanding the correlates of service use is important as the baby boomer generation moves into old age. From a policy and planning perspective, it is important to know if specific subgroups of older adults are disadvantaged regarding access to care so that appropriate interventions can be designed and implemented. In Canada, where health care coverage is universal, we might expect service use among older adults to be less influenced by non-need factors such as income, but this assumption has yet to be formally tested in this population.

In our paper, we examined the prevalence of service use, and the social, demographic, and need factors associated with the use of mental health care services among adults aged 55 years and older in a large, representative sample of Canadians. We applied the Andersen sociobehavioural model of health care[20–21] as a conceptual framework to guide our analysis. This model has been previously used to examine the population determinants of mental health care use in Canada[22] and the United States,[16,23–24] and is composed of 3 factors—predisposing, enabling, and need. Predisposing factors include sociodemographic characteristics such as sex, age, and education, and enabling factors are those resources such as income and social support, which influence access to care. Need characteristics are the objective and subjective experiences (illness and disease states) that prompt people to seek help. If predisposing and enabling characteristics strongly predict mental health care use independent of need, the assumption of equitable targeting of resources is challenged, and we must seek to understand why some social groups appear to be disadvantaged and to address this inequity.

Method

The CCHS 1.2[25] is a nationally representative community mental health survey conducted by Statistics Canada between May and December 2002. The target population included people aged 15 years and older living in private dwellings (98% of the population). People living in health care institutions, on First Nation reserves, on government-owned land, in 1 of the 3 northern territories, or in remote regions were excluded. Full-time members of the Armed Forces were sampled separately, and are not included in these analyses. One person was randomly selected from eligible households and a significant effort was made to interview respondents in person at their place of residence (86% of respondents). Interviews could be conducted in English, French, Chinese, or Punjabi (as required or requested by the interviewee). From the initially selected 48 047 households, there was an 86.5% household-level response rate, and among responding households there was an 89.0% person-level response rate. The overall response rate was 77.0%, resulting in a total sample size of 36 984 respondents. In our paper, we focused on respondents aged 55 years and older (n = 12 792). The decision to choose age 55 rather than the more traditional age of 65 was made for numerous reasons. First, many recent, large-scale surveys of psychiatric disorders in the general population have excluded people aged 55 years and older. Second, as people increasingly elect to retire earlier than age 65 or to stay in the labour force well past this age, the use of 65 to define entry to old age is becoming much less relevant.

Twelve-Month Mental Health Service Use

Respondents were asked if they had ever consulted any of a number of health professionals to discuss their emotions, mental health, or use of alcohol and drugs. These professionals included general practitioners, psychiatrists, other medical doctors, psychologists, nurses, social workers or counsellors, religious or spiritual advisers, and other professionals, the latter group including, for example, naturopaths, massage therapists, and dieticians. Respondents who indicated that they had contacted one or more of these professionals were then asked when their most recent contact occurred. From this question, we distinguished between respondents who reported service use for mental health reasons within the previous 12 months and those who accessed services in the past. We focused exclusively on 12-month service use as we were unable to ascertain when prior contact may have occurred. For example, previous mental health care use may have occurred a few years before the survey, or it may have occurred decades earlier. Moreover, we were particularly interested in whether 12-month disorder was associated with accessing care during the same time period. For these reasons, our analysis is limited to the 12-month measures of mental health care use.

Predisposing Factors

Predisposing factors included age, sex, marital status, and education. Age was measured in years, women were compared with men, and never married, widowed, and divorced or separated respondents were compared with married respondents. The attained level of education of the respondent included 3 categories: less than a high school diploma, high school graduation, and post-secondary education. In multivariate analyses, respondents with a post-secondary education were the reference group.

Enabling Characteristics

Enabling factors considered in this analysis included income adequacy, urbanicity, and social support. Respondents reporting low and middle income adequacy were compared with respondents in the high income group, and urban residents were compared with respondents who resided in a rural area. The CCHS 1.2 included 4 measures of social support from the MOS Social Support Survey[26] that measured tangible support, affection, positive social interaction, and emotional or informational support. However, exploratory factor analysis of the MOS using the CCHS 1.2 indicated that it is unifactorial, with a ratio of the first 2 eigenvalues of 9.8:1. After Promax rotation, factor loadings indicated a strong first factor and a weaker second factor composed of items relating

Table 1 Sample characteristics

Variable	Unweighted *n*	Proportion (95% CI)
Sex (female)	348	58.6 (52.4–64.8)
Marital status		
Married	224	57.9 (52.1–63.7)
Never married	39	6.0 (3.2–8.8)
Widowed	127	18.4 (14.0–22.8)
Separated or divorced	123	17.7 (13.7–21.6)
Income adequacy		
Low income	125	17.9 (13.8–22.1)
Middle income	147	27.9 (22.3–33.4)
High income	200	54.2 (48.8–60.6)
Education		
<Secondary diploma	213	38.6 (32.7–44.5)
Secondary diploma	79	18.3 (13.0–23.5)
Post-secondary	216	43.1 (37.0–49.3)
Residence location		
Urban	410	80.8 (75.9–85.6)
Rural	103	20.2 (14.4–24.1)
Any chronic conditions (1 = yes)	416	81.6 (76.8–86.3)
Any limitations in daily activities (1 = yes)	221	45.6 (39.4–51.8)
Poor self-rated mental health (1 = yes)	195	36.4 (30.8–41.9)
Variable	**Unweighted *n***	**Mean (95% CI)**
Age	513	63.7 (62.9–64.67)
Social support	512	57.4 (55.4–59.4)
Psychological distress	489	7.9 (7.2–8.7)

to respondents' access to practical help when in poor health (help if confined to bed, someone to take to a doctor, someone to prepare meals, and someone to help with daily chores if sick.) For this reason, we combined the 4 subscales into one measure of social support (range, 0 to 76).

Need Factors

Objective need was determined by fulfillment of the criteria for 1 or more of the 5 DSM-IV disorders (12-month depression, mania, social phobia, panic disorder, and agoraphobia) assessed in the survey. The WMH-CIDI was administered to respondents by trained lay interviewers. In multivariate analyses, we also considered the effect of comorbidity on service use, defined here as meeting the criteria for 2 or more 12-month disorders, compared with 1 disorder.

Subjective need was assessed using a global measure of psychological distress, as well as a measure of self-rated mental health. Psychological distress was assessed using the K6 symptom scale, with higher scores indicating greater perceived distress (range, 0 to 24).[27,28] Respondents were also asked to rate their mental health on a 5-point scale with response categories including excellent, very good, good, fair, or poor. We dichotomized this measure to compare respondents who indicated that their mental health was fair or poor with those respondents who indicated that their mental health was good, very good, or excellent.

Given the close association between physical and mental health in this population,[29] we also assessed the effect of chronic health conditions and limitations in ADL on mental health service use. Indeed, previous work has demonstrated that the presence of chronic conditions associated with chronic pain, such as arthritis and migraine headaches, was associated with an increased likelihood of mental health service use among older adults.[30] Respondents were asked about the presence of chronic physical health conditions that had been diagnosed by a medical professional and about limitations in ADL. A total of 10 chronic conditions were included: diabetes, asthma, arthritis, high blood pressure, chronic

Table 2 Mental health service use by type among respondents who report at least 1 DSM-IV diagnosis

Type of mental health care	*n*[a]	Frequency, % (95% CI)[b]
Any mental health care use	190	37.0 (30.9–43.0)
Any specialized mental health care use (psychiatrist, psychologist, social worker)	101	23.1 (17.1–28.6)
Any general mental health care use (family doctor, nurse)	154	31.4 (24.6–36.6)
Any other type of mental health care use	19	3.8 (0.9–5.9)

[a] Unweighted

[b] Weighted

bronchitis, heart disease, stomach ulcers, effects of stroke, migraine headaches, and urinary incontinence. An index was created summing yes responses to each health condition (range, 0 to 10). To assess limitations in ADL, respondents were asked if they required the help of another person with meal preparation, personal care, grocery shopping, chores around the house, heavy household chores, and moving about in their home. An index of the number of positive responses was created, with a higher number indicating greater limitations (range, 0 to 6).

Analysis

We selected people aged 55 years and older who met the 12-month criteria for at least one of the DSM-IV disorders measured in the CCHS 1.2 ($n = 513$). As our measure of service use is based on a 12-month retrospective reporting period, we focused on 12-month rather than lifetime disorder. We first estimated the proportion of older adults with disorder who sought specialized, general, and other care. Next, using logistic regression, we examined the relative contribution of predisposing, enabling, and need characteristics in predicting any service use in this population. We combined the various types of service providers in the multivariate analysis because of the relatively small sample sizes for each subgroup of providers. In Model 1, we entered predisposing characteristics only, followed by enabling characteristics in Model 2. In Model 3, we included subjective need characteristics, physical health problems, and the effect of meeting the criteria for more than one DSM-IV disorder. The CCHS 1.2 used a multistage, stratified cluster design to select eligible households. As a result, there is the potential for variance estimates to be underestimated. To remedy this potential bias, Statistics Canada recommends bootstrapping of all tests using a set of replicate weights that they provide. All prevalence and regression estimates were calculated with this approach using STATA 9.0 (STATA Corporation, College Station, TX).

Results

Sample characteristics are presented in Table 1. Among the 12 792 adults aged 55 years and older in the CCHS 1.2, 513 (4.2%, 95% CI 3.9% to 5.0%) met the criteria for at least one 12-month DSM-IV disorder. Among these respondents, depression was the most commonly reported disorder (58.6%, 95% CI 52.7% to 64.6%), followed by social phobia (29.3%, 95% CI, 23.9% to 34.7%), panic disorder (17.6%, 95% CI 12.5% to 22.6%), agoraphobia (13.7%, 95% CI 9.2% to 18.3%), and mania (5.8%, 95% CI 2.1% to 9.4%). About 19% of this sample met the criteria for 2 or more disorders.

Among the respondents with one or more disorders, 37% reported accessing at least one type of service in the previous 12 months (Table 2). Twenty-three percent reported using specialist mental health care, 31% reported accessing general care, and nearly 4% reported consultations with another type of provider.

In Table 3 we present the findings from the logistic regression analysis, assessing the potential predisposing, enabling, and need factors associated with any type of mental health care use. In Model 1, we included predisposing factors such as age, sex, marital status, and education. None of these predictors were significantly associated with mental health care use in the recent 12 months. In Model 2, we included enabling characteristics. Again, none of these predictors reached statistical significance. When we included need factors (Model 3), only current (past month) psychological distress was significantly and positively associated with an increased likelihood of accessing mental health care; for each unit increase in distress, respondents were 10% more likely to access some type of mental health care.

Discussion

The results of our study suggest that just over one-third (37%) of all older adults who met diagnostic criteria for 1 of the 5 12-month disorders assessed in the CCHS 1.2 also sought out some type of mental health care during that same time period. While most of these contacts (31%) occurred in general health settings (for example, family physicians), almost one-quarter (23%) occurred with mental health specialists (for example, psychiatrists and psychologists). These estimates of service use are considerably higher than those reported by Karlin et al,[16] but very close to those reported by Préville et al[15] and Klap et al.[11] Discrepancies between our findings and those reported by Karlin et al[16] may be related to differences in how psychiatric disorders were measured (CIDI, compared with a distress scale approximating CIDI—Short Form), and differences in the number of potential outpatient practitioners and settings that were queried. When compared with older adults in Quebec, older adults in the CCHS 1.2 were more likely to use speciality mental health services. As both surveys used similar methods and measures of service use and psychiatric disorder, differences could be due to the availability of specialized mental health care between Quebec and the rest of the country. Further

Table 3 Adjusted logistic regressions of mental health care use on predisposing, enabling, and need factors among respondents with at least 1 DSM-IV diagnosis (*n* = 513)

Predisposing, enabling, and need factors	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)
Age	0.98 (0.95–1.02)	0.98 (0.94–1.01)	0.99 (0.95–1.04)
Sex, female	0.74 (0.41–1.33)	0.76 (0.40–1.43)	1.17 (0.55–2.49)
Single	1.09 (0.37–3.18)	0.97 (0.31–3.00)	1.41 (0.43–4.60)
Widowed	1.18 (0.58–3.39)	0.94 (0.38–2.29)	1.07 (0.41–2.76)
Separated or divorced	1.26 (0.68–2.34)	1.33 (0.65–2.72)	1.55 (0.70–3.42)
<Secondary education	0.62 (0.34–1.11)	0.69 (0.36–1.34)	0.65 (0.32–1.31)
Secondary diploma	1.06 (0.46–2.44)	0.95 (0.38–2.40)	0.81 (0.31–2.09)
Urban residence		1.59 (0.65–3.88)	1.54 (0.64–3.72)
Low income		0.70 (0.30–1.60)	0.57 (0.23–1.42)
Middle income		0.52 (0.27–1.03)	0.50 (0.23–1.08)
Social support (MOS)		0.99 (0.97–1.00)	0.99 (0.98–1.01)
Psychological distress			1.10 (1.01–1.18)[a]
Poor self-rated mental health			1.67 (0.77–3.60)
Comorbidity (2 or more DSM-IV disorders)			2.23 (0.77–3.59)
Chronic health conditions			1.05 (0.38–2.91)
Limitations in ADL			0.51 (0.25–1.05)
–2 log likelihood	548.9	477.3	430.7

[a] $P < 0.05$

research exploring between-province differences in access to specialist care for this population is required.

Overall, our findings are also remarkably similar to recent, population-based data on the full age range in the United States. For example, using data from the NCS-R (including adults aged 55 years and older), Wang et al[10] reported that 41.1% of adults meeting 12-month diagnostic criteria for at least 1 of the 12 disorders assessed in the survey had received some type of treatment in the formal health care system in the 12 months before the time of the survey. A much lower percentage used specialist care (16% saw a psychiatrist), and even fewer sought care outside a medical setting altogether (6.8%).

Most other work on mental health services use among older adults is based on samples drawn from clinical settings.[31] Much less is known about the extent and predictors of service use among people who may or may not already be in the system for mental health care. Perhaps the most interesting finding of our study is a null one—outside of psychological distress, none of the predisposing and enabling characteristics were significantly related to access to care in this population. Even though a significant number of older adults with apparent need did not seek help, service use was not influenced by sex, marital status, socioeconomic status, or place of residence, factors often identified as structural barriers to care.[21–23] Although Karlin et al[16] looked at correlates of service use among all older adults in their sample, they reported nearly identical null findings regarding predisposing and enabling factors. Similarly, Klap et al[11] found health care insurance (for example, medicare) to be the only non-need factor associated with service use in adults aged 65 years and older. Regarding our data, it is tempting to conclude that because mental health care services are covered under a national health care program, barriers such as these are mitigated by the system. However, limitations in these data (see below) warrant caution.

The finding regarding distress is consistent with other studies that have used the Andersen model; need, in this case, perceived distress, was the strongest predictor of service use.[21] It is interesting to note that distress, rather than clinical disorder or psychiatric comorbidity, is the only significant predictor. Previous work has shown subjective mental health to be an independent predictor of service use,[32] regardless of diagnosis. That this may be the most important need-related factor associated with service use in older adults is a finding that warrants further investigation. At the same time, people with high levels of distress have been shown to overreport service use, when compared against administrative records of physician and use.[33,34] Further research that is not entirely reliant on self-reported service use is necessary to ascertain the

relative importance of distress as a predictor of access to care among older adults.

Assuming factors such as sex and income play little or no role in the use of mental health care, the question still remains: Why are older adults with a disorder not seeking care for mental health related problems? Other factors that may influence mental health help seeking in old age have been identified in the literature, including lack of knowledge about services, attitudes toward mental health care,[35] as well as lack of coordination of services for older adults, at least in the United States.[36] Such measures were not available in these data, but should be explored in further research.

As with any study, there are several limitations that need to be considered when evaluating the results. First, and perhaps most importantly, the prevalence of disorder in older adults is relatively low; therefore, even with large samples such as this one, both the number of older adults with disorder and the number seeking care are low. This reduces both statistical power to detect effects, and limits the complexity of the analysis, especially in relation to the number of covariates that can be included in multivariate models, and our ability to look at mental health care use for each disorder separately. From this research, we cannot say which disorder(s) prompted service use, only that perceived psychological distress, which was likely associated with all disorders, appeared to be the strongest need factor in seeking mental health care among those who met diagnostic criteria for at least 1 of the 5 disorders measured in the survey. Measures of numerous disorders, including more serious psychiatric disorders such as schizophrenia, personality disorders (for example, borderline personality disorder), as well as subthreshold disorders, were not available in these data. As such, the extent to which these disorders are associated with mental health care use, or may alter the findings reported here, is not known. Their exclusion may underestimate the proportion of adults with disorder in this age group, as well as related mental health care use, but this remains to be investigated empirically. Second, all data are based on self-report. Among other threats to validity of self-report measures, recall bias is particularly important when older adults are the focus of inquiry.[33] Third, conceptualizing the gap between self-reported need and reported use of services as unmet need is problematic for numerous reasons.[37] Chief among these is the concern over the validity of our measures for psychiatric disorder. For example, the CIDI has been criticized before as being overly sensitive, detecting minor psychological problems that may not require intervention.[38] Consideration of impairment to individual and social functioning, in addition to diagnostic criteria, is required to accurately assess unmet need. Data regarding the former are limited in the CCHS 1.2. Finally, as mentioned above, variables, such as perceived attitudes toward care, perceived stigma toward mental illness, and system level variables, such as access to coordinated services, are not available. Future work would also benefit from the inclusion of a broader range of disorders, including more serious psychiatric disorder, as well as disorders believed to be more prevalent in later life, such as GAD and cognitive impairment. Similarly, the inclusion of subthreshold disorders, which are also associated with significant morbidity,[39] would allow researchers to address their relation to mental health care use as well.

Conclusions

Notwithstanding these limitations, this is the first study to explore the prevalence and correlates of mental health care use in a nationally representative of older Canadians. Our findings show that even though overall prevalence of disorder may be lower in this age group, more than 60% who met the diagnostic criteria for 1 of the 5 disorders measured in the CCHS 1.2 did not seek help for mental health reasons. A better understanding of the underlying reasons for low levels of service use remains a priority for research efforts in this area.

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Résumé : Utilisation des soins de santé mentale au troisième âge : résultats d'un sondage national des Canadiens

Objectif : Estimer la proportion d'adultes âgés qui ont utilisé les services de santé mentale dans les 12 derniers mois parmi ceux qui satisfaisaient aux critères d'un ou de plusieurs troubles psychiatriques du Manuel diagnostique et statistique des troubles mentaux (DSM), 4e édition. Nous examinons également les facteurs associés à l'utilisation des soins de santé mentale dans cette population.

Méthode : Nous avons utilisé les données de l'Enquête sur la santé dans les collectivités canadiennes, Santé mentale et bien-être (ESCC 1.2). Nous avons d'abord estimé la proportion des adultes de 55 ans et plus qui utilisaient une gamme de services de santé mentale. Puis, à l'aide de la régression logistique, nous avons examiné l'apport relatif des variables de prédisposition, de habilitation, et de besoins à la prédiction de toute utilisation des services dans cette population.

Résultats : Parmi les 12 792 adultes de 55 ans et plus de l'ESCC 1.2, 513 (4,23 %; IC 95 % 3,89% à 4,95 %) satisfaisaient aux critères d'au moins un trouble de 12 mois du DSM-IV. Parmi ces répondants 37 % (IC 95 % 30,9 % à 43,0 %) ont vu au moins un type de prestataire de soins de santé mentale dans les 12 derniers mois. Les visites à un prestataire de soins de santé généraux pour des raisons de santé mentale étaient les plus fréquentes, suivies des soins d'un spécialiste. Seule la détresse psychologique était significativement et positivement associée à l'utilisation des services de santé mentale.

Conclusions : Plus de 60 % des adultes âgés qui satisfaisaient aux critères d'un trouble du DSM-IV n'utilisaient pas les services de santé mentale. Les facteurs sociaux et démographiques ne prédisaient pas l'utilisation des services dans cette population.